

ELECTRONIC FUNDS TRANSFER ENROLLMENT FORM

Please print or type. Complete information blocks in the unshaded areas only.

Vendor Code:			Vendor Name		
Vendor Address:			Vendor FEIN/SSN:		
ABA NO/CHCK Digit:			Bank Account Number:		
Bank ACCT DESCR:					
Bank Name:			Bank Address:		
Bank Address:			Bank Address:		
City	State	ZIP	Bank Telephone Number: ()		Ext
Circle C for Checking or S for Savings Check/Savings Ind: C or S		Status:	EFT Only Ind:		Interface Type:

By completing the information listed above, I hereby authorize the State of Louisiana, Division of Administration and their designees (**State**) to initiate ACH credit entries to the financial institution account listed as requested by the individual or organization above (Vendor) for payment of goods and services received or to withdraw overpayments owed to the **State** when the **State** determines that such collection is in the best interest of the **State**. I further authorize the State to withdraw funds from my account in the event that a check issued by the vendor listed above is returned for insufficient or uncollected funds to the State. This authorization is to remain in full effect until such time as the **State** is notified in writing by the vendor. This notification must include such time and be in such a manner as to afford reasonable time for the **State** to act on it. I certify that I am authorized to complete the information listed above in the unshaded areas on behalf of the individual or organization named above and resolve issues related to enrollment. The information presented above is true and correct for the individual or organization named above. I understand that by utilizing the State's EFT payment process, I will no longer receive remittance advices from the State of Louisiana for payments issued. I am instead to contact my financial institution for remittance information and I am utilizing a financial institution which has the capability to receive such information. The **State** reserves the right to issue a check for payment when the situation warrants. **I agree to notify the State of changes to the information listed on this form immediately. Failure to provide the State with correct information or failure to notify the State of changes to bank and/or account information will result in the Vendor bearing sole liability for lost and/or misdirected payments.**

Preparer's Signature:		Print Name:			
Title:		Date:		Phone #:	() ext
FOR USE OF THE OFFICE OF STATEWIDE REPORTING AND ACCOUNTING POLICY:					
Approved By:		Date:		Title:	